**ILLINOIS HEALTH FACILITIES PLANNING BOARD**
**INSTRUCTIONS FOR THE COMPLETION OF APPLICATION FOR EXEMPTION**
**CHANGE OF OWNERSHIP FOR AN EXISTING HEALTH CARE FACILITY**

The attached form must be used for all transactions proposing a change of ownership of a health care facility as defined in 77 Ill. Adm. Code Section 1130.140. The requirements for issuance of an exemption are contained in 77 Ill. Adm. Code Section 1130.520. Applicants should refer to Ill. Adm. Code 1130.140 for definitions of a change of ownership and control of a health care facility. Applicants should also refer to 77 Ill. Adm. Code 1130.220.b for information on who the applicant(s) or co-applicant(s) should be. Note the following requirements and guidelines pertaining to the Application for Exemption:

1. Ill. Adm. Code 1130.520(a) prohibits any person from acquiring or entering into an agreement to acquire an existing health care facility prior to receiving approval from the State Board. Contact staff if the change in ownership transaction has occurred or if there are questions regarding this matter.

2. Complete the application with all applicable attachments. All pages and documents must be on single-sided paper size 8 1/2"x11". Applicants should note that the required attachments to the application must be labeled and identified by attachment number. FAILURE TO DO SO WILL RESULT IN THE APPLICATION BEING INCOMPLETE.

3. ALL Hospitals, ALL governmental and ALL not-for-profit health care facilities should note the additional requirements contained in 77 Ill. Adm. Code Section 1130.520 b) c) & d) effective March 15, 1999. Affected applicants must address these additional requirements.

4. Applicants must submit a complete original application with original signature(s) and required appendices and attachments, AND TWO COMPLETE COPIES INCLUDING ALL APPENDICES AND ATTACHMENTS, as well as the APPLICATION FEE of $1,000.00 payable by check or money order to the Illinois Department of Public Health. Submit the material to:

   Ray Passeri, Executive Secretary
   Illinois Health Facilities Planning Board
   525 West Jefferson Street, Second Floor
   Springfield, Illinois 62761

5. Applicants should allow 30 DAYS from the date the State Agency receives the application for a determination of the application's completeness. PLEASE REFRAIN FROM TELEPHONING THE STATE AGENCY FOR A STATUS REPORT ON YOUR APPLICATION. STAFF TIME ANSWERING PHONE INQUIRIES TAKES FROM STAFF TIME TO REVIEW APPLICATIONS. The State Agency will contact you if your application is incomplete.

**NOTE**: **"The Illinois Department of Public Health does not discriminate on the basis of handicap in admission or access to, or treatment or employment in its programs and activities in compliance with Section 504 of the Rehabilitation Act of 1973, as amended. The Equal Employment Opportunity Officer is responsible for coordination of compliance efforts; voice (217) 785-2034; TDD (217) 785-2088."**

Application for Exemption
Change of Ownership
3-15-99 Edition Modified

(For Agency Use) Fee Received _____
Exemption # _____

**ILLINOIS HEALTH FACILITIES PLANNING BOARD**
**APPLICATION FOR EXEMPTION**
**CHANGE OF OWNERSHIP FOR AN EXISTING HEALTH CARE FACILITY**

**1. INFORMATION FOR EXISTING FACILITY**

Current Facility Name_____
Street & Number _____
City _____ Zip Code _____ County _____
Name of current licensed entity for the facility_____
Does the current licensee: own this facility ___ OR lease this facility___ (if leased, check if sublease □)
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
____ Limited Liability Company _____ Other, specify _____

**2. OUTSTANDING PERMITS.** Does the facility have any projects for which the State Board issued a permit that will not be completed (refer to 1130.140 "Completion or Project Completion" for a definition of project completion) by the time of the proposed ownership change? Yes □ No □. If yes, refer to Section 1130.520(e), and indicate the projects by project # _____

**3. FACILITY'S BED OR DIALYSIS STATION CAPACITY BY CATEGORY OF SERVICE**
(Complete **"APPENDIX A"** attached to this application form)

**4. FACILITY'S OTHER CATEGORIES OF SERVICE AS DEFINED IN 77 Ill. ADM. CODE 1100**
(Complete **"APPENDIX A"** attached to this application form)

**5. NAME OF APPLICANT (complete this information for each co-applicant, and insert after this page. Refer to 77 Ill. Adm. Code 1130.220.b for who the applicants should be).**
Exact Legal Name of Applicant _____
Address _____
City, State & Zip Code _____
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
____ Limited Liability Company _____ Other, specify _____

**6. NAME OF LEGAL ENTITY THAT WILL BE THE LICENSEE/OPERATING ENTITY OF THE FACILITY NAMED IN THE APPLICATION AS A RESULT OF THIS TRANSACTION.**
Exact Legal Name of Entity to be Licensed _____
Address_____
City, State & Zip Code _____
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
____ Limited Liability Company _____ Other, specify _____

**7. BUILDING/SITE OWNERSHIP. NAME OF LEGAL ENTITY THAT WILL OWN THE "BRICKS AND MORTAR" (BUILDING) OF THE FACILITY NAMED IN THIS APPLICATION IF DIFFERENT FROM THE OPERATING/LICENSED ENTITY**

Exact Legal Name of Entity That Will Own the Site_____
Address_____
City, State & Zip Code _____
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
____ Limited Liability Company _____ Other, specify _____

**8. TRANSACTION TYPE. CHECK THE FOLLOWING THAT APPLY TO THE TRANSACTION:**

- ☐ Purchase resulting in the issuance of a license to an entity different from current licensee;
- ☐ Lease resulting in the issuance of a license to an entity different from current licensee;
- ☐ Stock transfer resulting in the issuance of a license to a different entity from current licensee;
- ☐ Stock transfer resulting in no change from current licensee;
- ☐ Assignment or transfer of assets resulting in the issuance of a license to an entity different from the current licensee;
- ☐ Assignment or transfer of assets not resulting in the issuance of a license to an entity different from the current licensee;
- ☐ Change in membership or sponsorship of a not-for-profit corporation that is the licensed entity;
- ☐ Change of 50% or more of the voting members of a not-for-profit corporation's board of directors that controls a health care facility's operations, license, certification or physical plant and assets;
- ☐ Change in the sponsorship or control of the person who is licensed, certified or owns the physical plant and assets of a governmental health care facility;
- ☐ Sale or transfer of the physical plant and related assets of a health care facility not resulting in a change of current licensee;
- ☐ Any other transaction that results in a person obtaining control of a health care facility's operation or physical plant and assets, and explain in "Attachment 3 Narrative Description".

**9. APPLICATION FEE. Submit the application fee in the form of a check or money order for $1,000.00 payable to the Illinois Department of Public Health and append to the application as ATTACHMENT #1.**

**10. FUNDING. Indicate the type and source of funds which will be used to acquire the facility (e.g., mortgage through Health Facilities Authority; cash gift from parent company, etc.). Append this information to the application as ATTACHMENT #2.**

**11. ANTICIPATED ACQUISITION PRICE _____**

**12. FAIR MARKET VALUE OF THE FACILITY _____**
(for assistance in how to determine the fair market value, refer to 77 Ill. Adm. Code 1190.40(b))

**13. DATE OF PROPOSED TRANSACTION: _____**
(Note Ill. Adm. Code 1130.520(a) prohibits any person from acquiring or entering into an agreement to acquire a health care facility prior to approval from the State Board or Chairman of the State Board).

**14. NARRATIVE DESCRIPTION. Provide a narrative description explaining the transaction, and append it to the application as ATTACHMENT #3.**

**15. BACKGROUND OF APPLICANT. (Co-applicants must also provide this information) <u>Corporations and Limited Liability Companies</u> must provide a current Certificate of Good Standing from the Illinois Secretary of State. <u>Partnerships</u> must provide the name and address of each partner and specify whether each is a general or limited partner. Append this information to the application as ATTACHMENT #4.**

**16. TRANSACTION DOCUMENTS. Provide a copy of the document(s) which detail the terms and conditions of the proposed transaction (purchase, lease, stock transfer, etc). Applicants should note that the document(s) submitted should reflect the applicant's (and co-applicant's, if applicable) involvement in the transaction. Append this document(s) to the application as ATTACHMENT #5.**

**17. LEGAL NOTICE. Provide a copy of proof of publication of the required legal notice, and a copy of the required legal notice for the proposed transaction. Applicants should note that PROFESSIONAL AND TRADE ASSOCIATION PUBLICATIONS INTENDED TO SERVE A DEFINED POPULATION WILL NOT BE CONSIDERED A NEWSPAPER OF GENERAL CIRCULATION. (See 77 Ill. Adm. Code Section 1130.520c)&d)and "AGENCY NOTE"). Append this information to the application as ATTACHMENT #6. The legal notice must contain the following:**

A. the current name and address of the facility for which the exemption is sought;

B. the name and address of the applicant and (co-applicants) entity requesting the exemption;

C. the nature of the transaction (e.g., purchase, lease or stock transfer);

D. when the applicant is a wholly owned subsidiary of another corporation, provide the name and address of the parent firm;

E. a statement that all categories of service and beds currently provided will be maintained; and

F. the name, title, address and phone number of an individual from whom interested parties may obtain information on the proposed transaction.

**Note: Additional Legal Notice Requirements for ALL hospitals, governmental and other not-for-profit healthcare facilities (include in ATTACHMENT #6):**

G. a statement as to the anticipated benefits of the proposed change in ownership to the community;

H. the anticipated or potential cost savings, if any, that will result for the community and the facility as a result of the change in ownership;

I. a description of the mechanism that will be utilized to assure quality control;

J. a description of the applicant's organizational structure to include a listing of controlling or subsidiary persons;

K. a description of the selection process that the acquiring entity will utilize in selecting the hospital's board of directors;

L. a statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240, and that the response is available for public review on the premises of the health care facility;

M. the location, time and date of the public hearing which must be not less than 10 days not more than 30 days from the date of publication of the legal notice;

N. a statement that the hearing is an open public meeting at which time an opportunity will be afforded to all persons wishing to present written or oral comments.

**18. FINANCIAL STATEMENTS. (Co-applicants must also provide this information) Provide a copy of the applicant's latest audited financial statements, and append it to this application as ATTACHMENT #7. If the applicant is a newly formed entity and audited financials are not available, please indicate by checking "YES"_____, and indicate the date the entity was formed:_____.**

**19. ADDITIONAL REQUIREMENTS. The following are required additional attachments for ALL hospitals, ALL governmental and ALL not-for-profit health care facilities:**

A. Provide a certified copy of the transcript of the public hearing held on the proposed transaction and copies of all exhibits, documents and other written materials presented at the public hearing, and append it to the application as **ATTACHMENT #8.**

B. Provide a copy of the PROPOSED by-laws for the health care facility's governing body and medical staff, and append them to the application as **ATTACHMENT #9.**

C. Provide a copy of the EXISTING by-laws for the health care facility's governing body and medical staff, and append them to the application as **ATTACHMENT #10.**

D. Provide a copy of the EXISTING by-laws for the applicant's governing body and medical staff, and append them to the application as **ATTACHMENT #11.**

**20. PART 1110 CRITERIA. NOTE: all changes of ownership for hospitals, governmental and not-for-profit health care facilities must address the following on mergers, consolidations and acquisitions (refer also to Ill. Adm. Code 1110.240 and 1130.520b.14). Applicants are required to make this response available for inspection on the premises of the health care facility at least 10 days prior to the required public hearing for the transaction):**

A. IMPACT STATEMENT.
The applicant must submit an impact statement which reflects a two year period from the date of ownership change which details the following:
1). any proposed changes in the beds or services currently offered; and
2). who the anticipated operating entity will be; and
3). the reason for the transaction; and
4). any anticipated additions or reductions in employees; and
5). a cost/benefit analysis of the transaction.
Append this information to the application as **ATTACHMENT #12.**

B. ACCESS.
The applicant must document any changes which may result in the restriction of patient admissions and document that no reductions in access to care will result from the transaction. Documentation shall consist of a written certification that the admission policies of the facilities involved will not become more restrictive and the submission of both the current formal admission policies of all institutions involved and the anticipated policy following completion of the project. Append this information to the application as **ATTACHMENT #13.**

C. HEALTH CARE SYSTEM.
1). The applicant must document that:
a). the applicant's care system will not restrict the use of other area care providers; or
b). the transaction improves access to services previously unavailable in the community because of the structure of the applicant's care system.

2). Documentation must detail the current and proposed relationship with those health care or health related organizations which are to be owned (in whole or in part), affiliated, operated, or under management contract with the applicant and provide the following:
   a). all care system service providers and services offered including location, number of beds, and utilization levels for provided services over the last 12-month period; and
   b). the proposed relationship of the project to the care system. Data should include where referrals for categories of service not available at the proposed project will be made, how duplication of services will be resolved, time and travel factors involving referrals within the care system and any organization policies concerning the use of care system providers over other area providers.

   Append the information to the application as **ATTACHMENT #14.**

**21. PRIMARY CONTACT PERSON**. Individual representing the applicant to whom all correspondence and inquiries pertaining to this application are to be directed. (Note: other persons representing the applicant not named below will need written authorization from the applicant stating that such persons are also authorized to represent the applicant in relationship to this application).

Name _____
Address _____
City, State & Zip Code _____
Telephone (_____) _____ Ext. _____

**22. ADDITIONAL CONTACT PERSON.** Consultant, attorney, other individual who is also authorized to discuss this application and act on behalf of the applicant.

Name _____
Address _____
City, State & Zip Code _____
Telephone (_____) _____ Ext. _____

**23. CERTIFICATION**

I certify that the above information and all attached information is true and correct to the best of my knowledge and belief. I also certify that the categories of service, number of beds and/or dialysis stations within the facility will not change as part of this transaction. I certify that I am fully aware that a change in ownership will void any permits for projects that have not been completed unless such projects will be completed or altered pursuant to the requirements in 77 Ill. Adm. Code Section 1130.520(e) prior to the effective date of the proposed ownership change. I also certify that the applicant has not already acquired the facility named in this application or entered into an agreement to acquire the facility named in the application unless the contract contains a clause that the transaction is contingent upon approval by the State Board.

Signature of Authorized Officer _____
Typed or Printed Name of Authorized Officer _____
Title of Authorized Officer _____
Address _____
City, State & Zip Code _____
Telephone (_____) _____ Date _____

NOTE: complete a separate signature page for each co-applicant and insert following this page.

**APPENDIX A**

**FACILITY BED AND DIALYSIS STATION CAPACITY AND CATEGORIES OF SERVICE**

Complete the following for the facility for which the change of ownership is requested. The facility's bed and dialysis station capacity must be consistent with the State Board's Inventory of Health Care Facilities.

FACILITY NAME _____ CITY _____

1. Indicate (by placing an "X") the type of facility for which the change of ownership is requested:

   ☐ Hospital; ☐ Long-term Care Facility; ☐ Dialysis Facility; ☐ Ambulatory Surgical Treatment Center.

2. Provide the bed capacity by category of service:

| SERVICE | # of Beds | SERVICE | # of Beds |
|---|---|---|---|
| Medical/Surgical | _____ | Nursing Care | _____ |
| Obstetrics | _____ | Sheltered Care | _____ |
| Pediatrics | _____ | DD Adults* | _____ |
| Intensive Care | _____ | DD Children** | _____ |
| Acute Mental Illness | _____ | Chronic Mental Illness | _____ |
| Comp. Rehabilitation | _____ | Childrens Medical Care | _____ |
| Neonatal Intensive Care | _____ | Childrens Respite Care | _____ |
| Substance Abuse | _____ | | |
| Burn Treatment | _____ | | |

*Includes ICF/DD 16 and fewer bed facilities
**Includes skilled pediatric 22 years and under

3. Chronic Renal Dialysis: Enter the number of ESRD stations _____

4. Indicate (by placing an "X") those categories of service for which the facility is approved.

   ☐ Cardiac Catheterization
   ☐ Open Heart Surgery
   ☐ Intraoperative Magnetic Resonance Imaging
   ☐ High Linear Energy Transfer
   ☐ Postsurgical Recovery Care Center Model
   ☐ Therapeutic Radiology
   ☐ Subacute Care Hospital Model
   ☐ Kidney Transplantation
   ☐ Selected Organ Transplantation
   ☐ Positron Emission Scanning

5. Non-Hospital Based Ambulatory Surgery and Ambulatory Surgical Treatment Centers

   Indicate (by placing an "X") if the facility is a ☐ limited specialty or a ☐ multi-specialty facility and indicate the surgical specialties provided.

   ☐ Cardiovascular
   ☐ Dermatology
   ☐ Gastroenterology
   ☐ General/Other (includes any procedure that is not included in the other specialties)
   ☐ Neurological
   ☐ Obstetrics/Gynecology
   ☐ Ophthalmology
   ☐ Oral/Maxillofacial
   ☐ Orthopaedic
   ☐ Otolaryngology
   ☐ Plastic Surgery
   ☐ Podiatry
   ☐ Thoracic
   ☐ Urology